S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEVEL OF CARE EVALUATION

STAFFING REPORT

Individual's Name: _____

Social Security #: | | | | | | | | | |

The above named individual has been determined by the Office of Consumer Assessment to

☐ meet ☐ not meet

the Medicaid Level of Care criteria for ICF/MR.

Team Member Signatures:

_____

_____

_____

_____

_____

Physician Signature and Date:

_____

Evaluation Date: _____